CHAPTER 75-02-02.2
CHILDREN'S HEALTH INSURANCE PROGRAM

75-02-02.2-01. Definitions. For purposes of this chapter:

1. "American Indian or Alaska Native" means a member of a federally recognized Indian tribe, band, or group or a descendant in the first or second degree, of any such member; an Eskimo or Aleut or other Alaska native enrolled by the secretary of the interior pursuant to the Alaska Native Claims Settlement Act [43 U.S.C. 1601 et seq.]; a person who is considered by the secretary of the interior to be an Indian for any purpose; or a person who is determined to be an Indian under regulations promulgated by the secretary.

2. "Applicant" means an individual seeking benefits under the healthy steps program on behalf of a child.

3. "Asset" means any kind of property or property interest, whether real, personal, or mixed, whether liquid or illiquid, and whether or not presently vested with possessory rights.

4. "Children's health insurance program" means the North Dakota children's health insurance program, also known as the healthy steps program, which is a program implemented pursuant to North Dakota Century Code chapter 50-29 and 42 U.S.C. 1397aa et seq. to furnish health assistance to low-income children funded through title XXI of the Social Security Act [42 U.S.C. 1397aa et seq.].

5. "County agency" means the county social service board.

6. "Creditable health insurance coverage" means a health benefit plan which includes coverage for hospital or medical or major medical. The following are not considered creditable health insurance coverage:

   a. Coverage only for accident or disability income insurance;

   b. Coverage issued as a supplement to automobile liability insurance;

   c. Liability insurance, including general liability insurance and automobile liability insurance;

   d. Workforce safety insurance or similar insurance;

   e. Automobile medical payment insurance;

   f. Credit-only insurance;

   g. Coverage for onsite medical clinics;

   h. Other similar insurance coverage specified in federal regulations under which benefits for medical care are secondary or incidental to other insurance;

   i. Coverage for dental or vision;

   j. Coverage for long-term care, nursing home care, home health care, or community-based care;

   k. Coverage only for specified disease or illness;

   l. Hospital indemnity or other fixed indemnity insurance; and

   m. Coverage provided through Indian health services.

7. "Department" means the North Dakota department of human services.

8. "Disabled" has the same meaning as the term has when used by the social security administration in determining disability for title II or XVI of the Social Security Act [42 U.S.C. 301 et seq.].

9. "Earned income" means income currently received as wages, salaries, commissions, or profits from activities in which an individual or household is engaged through either employment or self-employment. There must be an appreciable amount of personal involvement and effort, on the part of the individual or household, for income to be considered "earned".

10. "Employer" means an individual or entity who employs the services of an applicant or a member of the applicant's household and who pays the individual wages, salaries, or benefits.

11. "Full calendar month" means the period which begins at midnight on the last day of the previous month and ends at midnight on the last day of the month under consideration.

12. "Household member" means any individual who shares the child's home a substantial amount of time. Children who are twenty-one years of age or older are not counted as household members. An individual who is temporarily absent from the household by reason of employment, school, training, or medical treatment, or who is expected to return to the household within thirty days of the date of the healthy steps program application, shall be considered a household member.

13. "Institutionalized individual" means an individual who is an inpatient in a nursing facility, an intermediate care facility for the mentally retarded, the state hospital, a residential treatment facility accredited by the joint commission on accreditation of health care organizations, the Anne Carlsen center for children, or an individual who receives swing-bed care in a hospital.

14. "Insurance carrier" means the insurance company that underwrites the insurance coverage for the children's health insurance program.

15. "Living independently" means an individual under the age of twenty-one who:

    a. Has served a tour of active duty with the armed services of the United States and lives separately and apart from either parent;

    b. Has married even though that marriage may have ended through divorce or separation. A marriage ended by legal annulment is treated as if the marriage never occurred;

    c. Has lived separately and apart from both parents for at least three consecutive full calendar months after the date the individual left the parental home, continues to live separately and apart from both parents, and has received no support or assistance from either parent while living separately and apart. Providing health insurance coverage or paying court-ordered child support payments for a child is not considered to be providing support or assistance. For purposes of this subdivision, periods when an individual is attending an educational or training facility, is receiving care in a specialized facility, or is an institutionalized person are deemed to be periods when the individual was living with a parent unless the individual previously established that the individual was living independently;

d. Has left foster care and established a living arrangement separate and apart from either parent and received no support or assistance from either parent. Providing health insurance coverage or paying court-ordered child support payments for a child is not considered to be providing support or assistance; or

e. Has lived separately and apart from both parents due to incest, continues to live separately and apart from both parents, and receives no support or assistance from either parent while living separately and apart. Providing health insurance coverage for a child is not considered to be providing support or assistance.

16. "Long-term care" means the services received by an institutionalized individual when the individual is screened or certified as requiring the services provided in a long-term care facility.

17. "Medicaid" means a program implemented pursuant to North Dakota Century Code chapter 50-24.1 and 42 U.S.C. 1396 et seq. to furnish medical assistance, as defined in 42 U.S.C. 1396d(a), to individuals determined eligible for medically necessary covered medical and remedial services.

18. "Poverty line" means the official income poverty line as defined by the United States office of management and budget and revised annually in accordance with 42 U.S.C. 9902(2).

19. "Public institution" means an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control.

20. "Specialized facility" means a residential facility, including a basic care facility, a licensed family foster care home for children or adults, a licensed group foster care home for children or adults, a transitional living facility, a facility established to provide quarters to clients of a sheltered workshop, and any other facility determined by the department to be a provider of remedial services, but does not mean an acute care facility or a nursing facility.

21. "Student" means an individual who regularly attends and makes satisfactory progress in elementary or secondary school, general equivalency diploma classes, home school program recognized or supervised by the student's state or local school district, college, university, or vocational training, including summer vacation periods if the individual intends to return to school in the fall. A full-time student is a person who attends school on a schedule equal to a full curriculum.

22. "Supplemental security income" or "SSI" means a program administered under title XVI of the Social Security Act [42 U.S.C. 1381 et seq.].

23. "Temporary assistance for needy families" means a program administered under North Dakota Century Code chapter 50-09 and title IV-A of the Social Security Act [42 U.S.C. 601 et seq.].

24. "The plan" means the North Dakota children's health insurance program.

25. "Title II" means title II of the Social Security Act [42 U.S.C. 401 et seq.].

26. "Title XVI" means title XVI of the Social Security Act [42 U.S.C. 1381 et seq.].

27. "Title XXI" means title XXI of the Social Security Act [42 U.S.C. 1397aa et seq.].

History: Effective October 1, 1999; amended effective August 1, 2005.
General Authority: NDCC 50-29
Law Implemented: NDCC 50-29-01; 42 USC 1397aa et seq.

75-02-02.2-02. Application, redetermination, and eligibility periods.

1. **Application.**

   a. Any individual who wishes to make application on behalf of a child for coverage must have the opportunity to do so without delay.

   b. An application is a written request for plan coverage to a county agency, the department, a disproportionate share hospital, as defined in section 1923(a)(1)(A) of the Social Security Act [42 U.S.C. 1396r-4(a)(1)(A)], or a federally qualified health center, as described in section 1905(l)(2)(B) of the Social Security Act [42 U.S.C. 1396d(l)(2)(B)].

   c. A prescribed application form must be signed by the applicant or appropriate individual on behalf of the child applying for plan coverage.

   d. Information concerning eligibility requirements, available services, and the rights and responsibilities of applicants and recipients must be furnished to all who request it.

   e. The date of the application is the date a signed application is received by the department, a county agency, a disproportionate share hospital, or a federally qualified health center. The department, county agency, disproportionate share hospital, or federally qualified health center must document the data an application is received.

2. **Redetermination.**

a. The department or county agency must redetermine a recipient's eligibility at least annually.

b. A recipient or anyone acting on a recipient's behalf has the same responsibility to furnish information during a redetermination of eligibility for coverage as an applicant has during the initial application.

c. Plan coverage terminates on the last day of the last month of the annual period if a recipient fails to provide sufficient information to redetermine eligibility.

3. **Eligibility periods.**

a. Eligibility for the children's health insurance program begins on the first day of the month following the month in which the eligibility determination is made.

b. The coverage period ends at the earliest of:

(1) The end of the twelve-month eligibility period;

(2) The end of the month in which the recipient turns age nineteen;

(3) The end of the month in which the recipient has obtained other creditable health insurance coverage;

(4) The end of the month in which the recipient leaves the household;

(5) The end of the month in which the recipient loses residency in the state; or

(6) When the recipient's whereabouts are unknown and mail directed to the recipient is returned by the post office indicating no known forwarding address.

History: Effective October 1, 1999; amended effective August 1, 2005.
General Authority: NDCC 50-29
Law Implemented: NDCC 50-29-02; 42 USC 1397aa et seq.

75-02-02.2-03. Duty to establish eligibility. It is the responsibility of the applicant or recipient to provide information sufficient to establish eligibility of each

child for whom coverage is requested including each child's social security number, age, residence, citizenship, and verification of financial eligibility.

History: Effective October 1, 1999; amended effective August 1, 2005.
General Authority: NDCC 50-29
Law Implemented: NDCC 50-29-03; 42 USC 1397aa et seq.

75-02-02.2-04. Decision, notice, and appeal.

1. The department or county agency shall make a decision as to eligibility within forty-five days of receipt of an application except in unusual circumstances.

2. Following a determination of eligibility or ineligibility, an applicant or recipient must be notified. The notice shall include the effective date of the action taken, the reason for the action taken, and the appeal rights, if any, of the applicant or recipient.

3. Errors made by public officials and delays caused by the actions of public officials do not create eligibility or additional benefits for coverage for a child who is adversely affected.

4. A notice informing an applicant or recipient of the right to appeal a decision made by the department must include a statement informing the applicant or recipient that a written appeal must be filed with the appeals supervisor of the department within thirty days after the date of the written notice of decision. The notice must inform the applicant or recipient that an appeal request must be mailed or delivered to the county agency or to:

   Appeals Supervisor
   Department of Human Services
   600 East Boulevard Avenue
   Judicial Wing, Dept. 325
   Bismarck, ND 58505

   Upon receipt of a timely filed appeal, the department shall conduct an administrative hearing in the manner prescribed in chapter 75-01-03 and render a decision within a reasonable time. Because plan benefits are not an entitlement pursuant to 42 U.S.C. section 1397bb(b)(4) and North Dakota Century Code section 50-29-05, the hearing provided for in this subsection must be one in accordance with the requirements of 42 C.F.R. section 457.1130 and shall not be one required under due process provisions of the fourteenth amendment to the United States Constitution as applied in Goldberg v. Kelly, 397 U.S. 254(1970) or its progeny.

5. A recipient may file a grievance, complaint, or appeal regarding a determination made by the insurance carrier that is under contract

with the department to provide the insurance coverage for the plan that results in a reduction or denial of benefits. The recipient must file the grievance, complaint, or appeal with the insurance carrier in the manner provided for by the insurance carrier subject to North Dakota law regarding grievance and appeal procedures required for health insurance carriers in effect at the time the action appealed from was taken. If the recipient is dissatisfied with the final decision of the insurance carrier after exhausting all available remedies provided by the insurance carrier, the recipient may appeal the decision to the department in the manner provided in subsection 4.

6. When a recipient requests an appeal of suspension or termination of plan coverage prior to the effective date of the suspension or termination, the recipient's eligibility may not be terminated until a decision is rendered unless it is determined that the sole issue is one of federal or state law or policy. The recipient must be informed in writing if benefits will not continue because the sole issue of the appeal is one of federal or state law or policy.

7. When children's health insurance program benefits have continued pending a decision on the applicant or recipient's appeal and the decision to deny or terminate benefits is upheld, the recipient's eligibility must be terminated effective the end of the month of receipt of the notice of the decision.

History: Effective October 1, 1999; amended effective August 1, 2005.
General Authority: NDCC 50-29
Law Implemented: NDCC 50-29-02; 42 USC 1397aa et seq.

75-02-02.2-05. Notice of potential medicaid eligibility - Choice of program. Repealed effective August 1, 2005.

75-02-02.2-06. Renewal of eligibility. Repealed effective August 1, 2005.

75-02-02.2-06.1. Children's health insurance program unit. A plan unit may consist of one individual, a married couple, or a family with children under twenty-one years of age, or if disabled, under age eighteen, whose income is considered in determining eligibility for any member of that unit, without regard to whether the members of the unit all physically reside in the same location. A parent or other caretaker of children under twenty-one years of age may select the children who will be included in the plan unit. Anyone who is included in the unit for any month is subject to all plan requirements which may affect the unit. The financial responsibility of relatives must be considered with respect to all members of the assistance unit.

History: Effective August 1, 2005.
General Authority: NDCC 50-29
Law Implemented: NDCC 50-29; 42 USC 1397aa et seq.

75-02-02.2-07. Duty to report changes in household. A recipient or household member shall immediately report to the department or county agency:

1. A child leaving the household;

2. A household gaining access to other health insurance coverage for the child;

3. A child leaving the state of North Dakota; or

4. A child being born into the household.

History: Effective October 1, 1999; amended effective August 1, 2005.
General Authority: NDCC 50-29
Law Implemented: NDCC 50-29; 42 USC 1397aa et seq.

75-02-02.2-08. Termination of coverage by recipient.

1. A recipient, or appropriate individual on behalf of the recipient, may terminate coverage under the plan by providing a written notice to the department or county agency requesting such action.

2. An oral request for termination of coverage made by a recipient, or appropriate individual on behalf of the recipient, is effective if recorded in the case file and reflected on the termination notice.

History: Effective October 1, 1999; amended effective August 1, 2005.
General Authority: NDCC 50-29
Law Implemented: NDCC 50-29; 42 USC 1397aa et seq.

75-02-02.2-09. Residence and citizenship requirements. The residency requirements provided in section 75-02-02.1-16 and the citizenship and alienage requirements provided in section 75-02-02.1-18 apply to plan applicants and recipients.

History: Effective October 1, 1999; amended effective August 1, 2005.
General Authority: NDCC 50-29
Law Implemented: NDCC 50-29; 42 USC 1397aa et seq.

75-02-02.2-10. Eligibility criteria.

1. Children ages birth through eighteen years of age are eligible for plan coverage provided all other eligibility criteria are met. Coverage for children who are eighteen years of age will continue through the last day of the month in which the child turns nineteen years of age.

2. A child who has current creditable health insurance coverage or has coverage which is available at no cost, as defined in section 2701(c)

of the Public Health Service Act [42 U.S.C. 300gg(c)] is not eligible for plan coverage.

3. A child is not eligible for plan coverage if a family member voluntarily terminated either employer-sponsored or individual health insurance coverage of the child within six months of the date of application unless:

   a. The health insurance coverage was terminated due to the involuntary loss of employment;

   b. The health insurance coverage was terminated through no fault of the family member who had secured the coverage; or

   c. The health insurance coverage was terminated by a household member who is actively engaged in farming in a county which is declared a federal disaster area.

4. Except as provided in subsection 6, the public institution provisions of section 75-02-02.1-19 apply to healthy steps applicants and recipients.

5. A child who meets current medicaid eligibility criteria is not eligible for plan coverage unless the child would otherwise be eligible for the medically needy medicaid program with a recipient liability. Such child may be enrolled in either the healthy steps program or the medically needy medicaid program.

6. A child who resides in an institution for mental disease at the time an eligibility determination is made is not eligible for plan coverage. A child who enters an institution for mental disease while receiving plan coverage may remain eligible for coverage.

7. If the department estimates that available funds are insufficient to allow plan coverage for additional applicants, the department may take any action appropriate to avoid commitment of funds in excess of available funds including denying applications and establishing waiting lists not forbidden by title XXI of the Social Security Act [42 U.S.C. section 1397aa et seq.] or regulations adopted thereunder. If federal children's health insurance program funding decreases, the department may decrease the income eligibility limit to accommodate the decrease in federal funding.

8. A social security number must be furnished as a condition of eligibility for each child for whom benefits are sought except for:

   a. A newborn child beginning on the date of birth and for the remaining days of the current eligibility period; and

b. Children who have applied for, but not yet received, social security numbers.

History: Effective October 1, 1999; amended effective April 1, 2002; August 1, 2005.
General Authority: NDCC 50-29
Law Implemented: NDCC 50-29; 42 USC 1397aa et seq.

75-02-02.2-11. Asset considerations. Assets may not be considered in determining eligibility for plan coverage.

History: Effective October 1, 1999.
General Authority: NDCC 50-29
Law Implemented: NDCC 50-29; 42 USC 1397aa et seq.

75-02-02.2-12. Income considerations.

1. All income that is actually available must be considered. Income is actually available when it is at the disposal of an applicant, recipient, or responsible relative when the applicant, recipient, or responsible relative has a legal interest in a liquidated sum and has the legal ability to make the sum available; or when the applicant, recipient, or responsible relative has the lawful power to make the income available or to cause the income to be made available.

2. It is presumed that all parental income is actually available to a child under twenty-one years of age. This presumption may be rebutted by a showing that the child is:

   a. Living independently; or

   b. Living with a parent who is separated from the child's other parent, with or without court order, if the parents did not separate for the purpose of securing plan coverage.

3. As a condition of eligibility, an applicant, recipient, and financially responsible relative must take all necessary steps to obtain any annuities, pensions, retirement, and disability benefits to which they are entitled unless they can show good cause for not doing so. Annuities, pensions, retirement, and disability benefits include veterans' compensation and pensions; old-age, survivors, and disability insurance benefits; railroad retirement benefits; and unemployment compensation.

   a. Good cause under this section exists if receipt of the annuity, pension, retirement, or disability benefit would result in a loss of health insurance coverage. Good cause must be documented in the case file.

b. Application for needs-based payments such as social security supplemental security income benefits or temporary aid to needy families benefits cannot be imposed as a condition of eligibility.

4. The financial responsibility of any individual for any other member of the plan unit will be limited to the responsibility of spouse for spouse and parents for children under age twenty-one or under age eighteen if the child is disabled. Such responsibility is imposed as a condition of plan eligibility. Except as otherwise provided in this section, the income of the spouse and parents is considered available even if that income is not actually contributed. Natural and adoptive parents, but not stepparents, are treated as parents.

5. Income may be received weekly, biweekly, monthly, intermittently, or annually. A monthly income amount must be computed by the department or county agency regardless of how often income is received.

6. The following types of income must be disregarded in determining eligibility for plan coverage:

   a. Supplemental security income benefits provided by the social security administration.

   b. Income disregards in subdivisions a through q and s through nn of subsection 1 of section 75-02-02.1-38.2.

7. a. In determining ownership of income from a document, income must be considered available to each individual as provided in the document or in the absence of a specific provision in the document:

      (1) Income shall be considered available only to the individual if payment of the income was made solely to that individual; and

      (2) Income shall be considered available to each individual in proportion to the individual's interest if payment of income is made to more than one individual.

   b. One-half of income shall be considered available to each spouse in the case of income available to a married couple in which there is no document establishing ownership otherwise.

   c. Except in the case of income from a trust, the rules for determining ownership of income are superseded to the extent that the applicant or recipient can establish that the ownership interests are otherwise than as provided in subsection 6.

8. To determine the appropriate income level for a plan unit:

   a. The size of the household is increased by one for each unborn child of a household member;

   b. A child who is away at school is not treated as living independently, but is allowed a separate income level for one in addition to the income level applicable for the family unit remaining at home;

   c. A child who is living outside of the parental home but who is not living independently; or a spouse who is temporarily living outside of the home to attend training or college, to secure medical treatment, because of temporary work relocation required by an employer, or for other reasons beyond the control of the spouse, is allowed a separate income level. This does not apply to situations in which an individual simply decides to live separately;

   d. An individual in a specialized facility is allowed a separate income level for one during all full calendar months in which the individual resides in the facility;

   e. An individual in a nursing facility is allowed a separate income level for one; and

   f. A recipient of home and community-based services is allowed a separate income level for one.

9. In order for a child to be eligible for plan coverage, the income remaining after allowing the appropriate disregards and deductions must be equal to or below one hundred forty percent of the federal poverty line based on the size of the household unless federal children's health insurance program funding decreases in which case the department may decrease the income eligibility limit to accommodate the decrease in federal funding.

History: Effective October 1, 1999; amended effective April 1, 2002; August 1, 2005.
General Authority: NDCC 50-29
Law Implemented: NDCC 50-29-02; 42 USC 1397aa et seq.

75-02-02.2-13. Determining household income.

1. Unearned income is income that is not earned income. Unearned income received in a fixed amount each month shall be applied in the month in which it is normally received.

   a. Recurring unearned lump sum payments received after application for medicaid under chapter 75-02-02.1 or the children's health insurance program shall be prorated over the number of months

the payment is intended to cover. When a payment is received and prorated in an ongoing case, or after a period of medicaid or children's health insurance program eligibility, and the case is closed and then reopened during the prorated period, or within the following proration period, the lump sum payment proration must continue.

b. All nonrecurring unearned lump sum payments, except health or long-term care insurance payments, veterans administration aid and attendance, veterans administration reimbursements for unusual medical expenses, and veterans administration homebound benefits intended for medical expenses shall be considered as income in the month received and assets thereafter.

c. One-twelfth of the annual amount of lease payments not otherwise required to be disregarded under section 75-02-02.1-38.2 deposited in individual Indian moneys accounts by the bureau of Indian affairs is income in each month and shall be determined:

(1) By totaling all payments in the most recent full calendar year and dividing by twelve;

(2) By totaling all payments in the twelve-month period ending with the previous month and dividing by twelve; or

(3) If the applicant or recipient demonstrates, by furnishing lease documents or reports, that the deposit amount will be substantially different than the annual amount which would be determined under subdivision a or b, by totaling all payments likely to be made in the twelve-month period beginning with the month in which the lease arrangement changed and dividing by twelve.

2. Earned income is income that is currently received as wages, salaries, commissions, or profits from activities in which an individual or family is engaged through either employment or self-employment. Income is earned only if the individual or family contributes an appreciable amount of personal involvement and effort to the production of that income. Earned income shall be applied in the month in which it is normally received. If earnings from more than one month are received in a single payment, the payment must be divided by the number of months in which the income was earned and the resulting monthly amounts shall be attributed to each of the months with respect to which the earnings were received.

3. Self-employment income must be calculated as follows:

a. Self-employment income must be calculated based on the previous year of self-employment and if the plan unit fails to qualify for plan

eligibility, the self-employment income must be calculated based on the average of the previous three years of self-employment from that business. If the business has been in operation for less than three consecutive years, the actual number of years of business operation must be used to calculate the average yearly income.

b. Monthly self-employment income is one-twelfth of the business income or loss calculated from an individual's income tax form 1040 and capital gains or losses related to self-employment business, less one-twelfth of the adjusted gross income deduction from page one of the individual's income tax form 1040. If a unit has more than one self-employment business, only one adjusted gross income deduction is allowed.

c. For a business that has been operating for less than a full tax year, monthly self-employment income is the business income or loss from the individual's income tax form 1040 and capital gains and losses related to the self-employment business, divided by the number of months the business has been in operation and less one-twelfth of the adjusted gross income deductions from page one of the individual's income tax form 1040. If a plan unit has more than one self-employment business, only one adjusted gross income deduction is allowed.

d. For a business that is not included on a tax return, business records and ledgers reflecting income and expenses must be used to calculate monthly self-employment income.

History: Effective October 1, 1999; amended effective April 1, 2002; August 1, 2005.
General Authority: NDCC 50-29
Law Implemented: NDCC 50-29-02; 42 USC 1397aa et seq.

75-02-02.2-13.1. Income deductions. The following deductions must be subtracted from monthly income to determine adjusted gross income:

1. For household members with countable earned income:

   a. Actual mandatory payroll deductions, including federal, state, or social security taxes or ninety dollars per month, whichever is greater;

   b. Mandatory retirement plan deductions;

   c. Union dues actually paid; and

   d. Expenses reasonably attributable to earning income;

2. Reasonable child care expenses, not otherwise reimbursed by third parties if necessary to engage in employment or training; and

3. Except for a support payment withheld from an extra check that is disregarded, nonvoluntary child and spousal support payments if actually paid by a parent on behalf of an individual who is not a member of the household.

History: Effective August 1, 2005.
General Authority: NDCC 50-29
Law Implemented: NDCC 50-29-02; 42 USC 1397aa et seq.

75-02-02.2-13.2. Budgeting.

1. For purposes of this section:

   a. "Base month" means the calendar month prior to the processing month.

   b. "Benefit month" means the calendar month for which eligibility is being computed.

   c. "Best estimate" means an income, expense, or circumstance prediction based on past amounts of income and expenses and known factual information concerning future circumstances which affect eligibility; expenses to be incurred; or income to be received in the benefit month. Factual information concerning future circumstances must be based on information by which the applicant or recipient demonstrates known changes or highly probable changes to the income, expense, or circumstances which offset eligibility, from the base month to the benefit month.

   d. "Processing month" means the month between the base month and the benefit month.

   e. "Prospective budgeting" means computation of a household's eligibility based on the best estimate of income, expenses, and circumstances for a benefit month.

2. For applications and redeterminations, the department and county agency must use prospective budgeting to determine financial eligibility for the benefit month.

3. A child who is eligible for the benefit month remains eligible for the rest of the period and no further monthly budget will be calculated until the next redetermination of eligibility is due.

4. The same budgeting applies regardless of whether an individual lives in the individual's own home, a specialized facility, or a nursing facility.

5. Excess income of a spouse or parent may be deemed to a spouse or child who is in the plan unit but who has a separate income level to increase that spouse's or child's income to the children's health insurance program income level. Excess income is the amount of net income remaining after allowing the appropriate disregards, deductions, and income level.

History: Effective August 1, 2005.
General Authority: NDCC 50-29
Law Implemented: NDCC 50-29-02; 42 USC 1397aa et seq.

75-02-02.2-14. Eligibility period. The coverage effective date for children other than newborn children is the first day of the month following the determination of eligibility. A newborn child born into a family that already has a child enrolled in the children's health insurance program may be covered effective on the date of the newborn's birth but not prior to the approval date of the case. The coverage period ends at the earliest of:

1. The last day of the twelfth month after enrollment;

2. The end of the month the child turned nineteen years of age;

3. The end of the month in which the child has obtained other health insurance coverage; or

4. The end of the month in which the child leaves the household unless waived by the department.

History: Effective October 1, 1999; amended effective April 1, 2002; August 1, 2005.
General Authority: NDCC 50-29
Law Implemented: NDCC 50-29-04; 42 USC 1397aa et seq.

75-02-02.2-15. Covered services. Within any limitations that may be established by rule, regulation, or statute and within the limits of legislative appropriations and subject to copayments that are the responsibility of the recipient, eligible children may obtain the medical and remedial care and services that are described in the approved state plan for the healthy steps program in effect at the time the service is rendered.

History: Effective October 1, 1999; amended effective August 1, 2005.
General Authority: NDCC 50-29
Law Implemented: NDCC 50-29-04; 42 USC 1397aa et seq.